FORM 110-O
HRNG LOSS/OCC DIS
Revised July, 2006

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, KY 40601

AGREEMENT AS TO COMPENSATION AND ORDER APPROVING SETTLEMENT

Workers' Compensation Claim No. _____

IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.

Every section should be completed. If a section if not applicable, fill in the blank with N/A.

_____ Claimant

_____ Social Security Number Date of Birth

_____ Address

_____ City, State, Zip Code

_____ Employer

_____ Address

_____ City, State, Zip Code

_____ Insurer/Self-Insured/Self-Insurance Group

_____ Insurer's Address

_____ City, State, Zip Code

_____ Other participating parties

_____ Address

_____ City, State, Zip Code

HEARING LOSS OR OCCUPATIONAL DISEASE: INJURIOUS EXPOSURE

Occupational disease: _____ Cause of disease:_____
Date of last exposure: _____County in which exposure occurred:_____
Brief description of history of exposure_____

_____
Body part(s) affected:_____ Length of exposure:_____

MEDICAL INFORMATION

Medical expenses paid: $_____ Date of last medical payment:_____
Medical expenses unpaid or contested: $_____
Surgery performed: *(circle one)* Yes No
Nature of surgery:_____
Impairment ratings: (Attach entire medical report that provides ratings)

	Date Given	Physician
_____%	_____	_____
_____%	_____	_____
_____%	_____	_____

Restrictions on activities—Attach most recent medical report setting forth physical restrictions.
Diagnosis or diagnoses:_____
If medical treatment is continuing, attach a copy of the executed Form 113 indicating a designated physician.

WORK INFORMATION

Type of work at last exposure:_____
Average weekly wage at time of last exposure: $_____ Date of return to work:_____
Wages upon return to work: $_____ Type of work performed after return:_____
Type of work performed at time of settlement:_____

BENEFIT AND SETTLEMENT INFORMATION

If consolidated claims, indicate amount for each claim separately:

Temporary total disability paid from _____ to _____@ $_____ * _____=$_____
(MM/DD/YR) (MM/DD/YR) Amount # of wks Total
Monetary terms of settlement: _____, paid in lump sum:_____, or weekly for _____ weeks
Settlement computation:_____
TTD*IMP RATING*AMA FACTOR*RTW FACTOR*DISC FACTOR OR # OF WKS=TOTAL

Please circle:			Amount of Waiver(s)
Waiver or buyout of past medical benefits	Yes	No	_____
Waiver of buyout of future medical benefits	Yes	No	_____
Waiver of vocational rehabilitation	Yes	No	_____
Waiver of right to reopen	Yes	No	_____

Does settlement include Medicare Set Aside? Yes No If yes, amount of Medicare Set Aside:_____
Lump Sum

Periodic Payments: _____*_____*_____ = _____
Amount Frequency Duration Total

Other: Attach explanation

If settlement terms provide for lump sum representing weekly benefits greater than $100, does claimant have an adequate source of income during disability? Yes No
Source of income:_____ Amount: $_____
Does settlement include retraining benefits? Yes No
If yes, is claimant actively participating in instruction or training program? Yes No
Name of instruction or training program (Attach additional pages if necessary):_____
_____
_____

OTHER INFORMATION

If additional information is pertinent to settlement, explain, (Attach additional pages if necessary):
_____
_____
Other responsible parties against who further proceedings are reserved:_____
_____

If waiving medical benefits, please acknowledge by signing below:
I understand that my health insurance may not cover any medical expenses for my injury and I may be held responsible for payment of medical expenses for my injury.

_____
Claimant (Signature)

If not represented by an Attorney, please acknowledge by signing below:
I understand that I have a right to obtain an Attorney of my choice to review the Agreement and by signing below I acknowledge that I have waived that right. By waiving that right, I understand I will be held to the same standard as an Attorney and this Agreement will be enforceable as if represented by Attorney.

_____
Claimant (Signature)

_____
Attorney or representative for claimant (Signature)

_____
Attorney or representative for claimant (Name typed)

_____
Address

_____
City, State, Zip

_____
Claimant (Signature)

_____
Attorney or representative for employer (Signature)

_____
Address

_____
City, State, Zip

_____
Attorney for Special Fund (Div. or Workers' Comp Funds)

This the _____ day of _____, 20_____.

DO NOT WRITE OR MAKE BELOW THIS LINE

ORDER APPROVING SETTLEMENT AGREEMENT

IT IS ORDERED that the above Agreement as to Compensation be and the same is hereby **APPROVED.**

This the _____ day of _____, 20_____.